Factors Influencing Anticipatory Self-efficacy of Pregnant Women in Coping with Labour Pain in First Stage of Labour in a Secondary Health Facility in Ogun State

Olubukunola Adesola Ajayi
School of Nursing Science,Babcock University, Ilishan-Remo, Ogun State

Olaide Olasubomi Sodiya
School of Nursing Science,Babcock University, Ilishan-Remo, Ogun State

Toliah Abiodun Arogundade
School of Nursing Science, Babcock University, Ilishan-Remo, Ogun State

Subuola Christiana Aderibigbe
School of Nursing Science,Babcock University, Ilishan-Remo, Ogun State

Mary Ayodeji Olofin-Samuel
Department of Nursing, Faculty of Basic Medical Sciences, Ekiti State University, Ado - Ekiti, Ekiti State

Funke Sulyman
School of Nursing Science,Babcock University, Ilishan-Remo, Ogun State

Badejoko Alice Ogunrinde
School of Nursing Science,Babcock University, Ilishan-Remo, Ogun State

Abstract: *This study investigated the factors influencing the anticipatory self-efficacy of pregnant women in coping with labour pain during the first stage of labour at State Hospital, Ijaiye, Abeokuta, Ogun State. The research specifically assessed the influence of socio-*

demographic and obstetric variables such as age, educational status, parity, and previous labour experience on women's anticipatory self-efficacy. A non-experimental descriptive design was adopted, and 136 pregnant women were selected using a convenience sampling method, with 125 valid responses analysed. Inclusion criteria included multigravida women with previous vaginal delivery and no complications. Data were collected through a structured, self-developed questionnaire incorporating two subscales of the Childbirth Self-Efficacy Inventory (CBSEI), adapted and translated into Yoruba. The instrument showed good reliability (Cronbach's alpha = 0.75). Statistical analyses including chi-square, ANOVA, and t-tests were conducted using SPSS version 20. Findings revealed a significant relationship between socio-demographic factors and anticipatory self-efficacy (χ^2 = 16.909, p = 0.007). Obstetric factors such as parity and previous labour experience were also significantly associated with anticipatory self-efficacy (χ^2 = 28.899, p = 0.012). Women with higher parity and positive prior experiences reported higher self-efficacy. Although the majority of respondents exhibited average levels of anticipatory self-efficacy (mean = 42.565), a need for improvement was identified. The study concludes that targeted nursing interventions during antenatal care can enhance women's confidence and coping abilities. Recommendations include incorporating self-efficacy training into antenatal classes and providing personalised support based on demographic and obstetric history to foster positive birth outcomes and maternal well-being.

Keywords: anticipatory self-efficacy, labour pain coping, pregnant women, obstetric factors, first stage of labour

INTRODUCTION

Anticipatory self-efficacy in coping with labour pain, particularly in the first stage of labour, is a crucial aspect of maternal health, as it significantly shapes the childbirth experience of pregnant women. During this initial stage, characterised by the onset of regular contractions and progressive cervical dilation, women often encounter unpredictable and intensifying pain. This pain is not only physiological but also psychologically overwhelming for many, especially for first-time mothers with limited exposure to coping mechanisms (Timmermans, et al., 2019). The lack of preparedness or inadequate knowledge about pain management strategies often leaves women entering the labour room unsure of how to effectively handle the discomfort (Korn et al., 2021; Ejioye & Gbenga-Epebinu 2021). The societal expectation for women to endure labour pain naturally, without overt distress, can further exacerbate feelings of helplessness. Consequently, without anticipatory coping skills rooted in self-efficacy, many women may face the first stage of labour with fear and anxiety, reducing their pain threshold and overall childbirth satisfaction (Wittkowski et al., 2017; Kjeldsen et al., 2022).

The first stage of labour typically presents as one of the most painful and prolonged phases, and it deeply influences the woman's emotional, physical, and psychological well-being. Studies

have shown that this stage involves a gradual increase in contraction intensity, abdominal discomfort, pelvic pressure, and back pain (Šalanská, et al, 2019. Coping with this discomfort requires more than just physical endurance; it demands mental resilience and confidence in one's ability to manage the experience. Anticipatory self-efficacy reflects a woman's belief in her capacity to engage in effective pain-coping behaviours even before labour begins. When women enter labour with positive expectations, emotional strength, and a supportive environment, their perceived ability to manage pain improves significantly. However, when emotions are dominated by fear or uncertainty, the resulting stress response may increase pain sensitivity, hinder cervical dilation, and negatively influence the labour trajectory.

Non-pharmacological pain relief strategies have been highlighted as effective methods in enhancing self-efficacy and improving the childbirth experience. These include breathing techniques, relaxation exercises, massage, hydrotherapy, use of heat or cold compresses, and even music therapy (Conqueiro,et al., 2017). While no single method guarantees total relief, a combination of these techniques can provide women with a sense of control and active participation in their birthing process. Bandura's theory of self-efficacy outlines two key constructs: self-efficacy expectancy and outcome expectancy. Women may understand that certain behaviours can reduce pain (outcome expectancy) but may lack confidence in their ability to perform them effectively (self-efficacy expectancy). Hence, antenatal education and continuous psychological support are necessary to strengthen a woman's belief in her own coping capabilities during labour, particularly in its early and more unpredictable phase.

Several factors have been identified to influence anticipatory self-efficacy, particularly in relation to the first stage of labour. These include age, educational attainment, parity, previous birth experiences, and cultural beliefs. The interplay of these factors determines how a woman perceives her ability to withstand and manage labour pain. High self-efficacy is associated with reduced anxiety, improved emotional stability, and decreased reliance on surgical interventions such as caesarean sections. Moreover, women with robust self-efficacy demonstrate better psychological adjustment, report lower pain intensity, and generally experience a more satisfying childbirth process (Fereshteh, 2002; Tilden & Caughey, 2016). Given the physical and emotional demands of the first stage of labour, it is crucial to empower pregnant women through targeted interventions that enhance their confidence and readiness to cope. Understanding and addressing the underlying factors that shape anticipatory self-efficacy is therefore central to improving maternal outcomes in secondary health facilities such as the State Hospital, Ijaiye Abeokuta.

The main objective of this study was to determine the factors, including socio-demographic and obstetric variables, that influence the anticipatory self-efficacy of pregnant women in coping with labour pain during the first stage of labour at the State Hospital, Ijaiye, Abeokuta, Ogun State. Specifically, the study aimed to assess the socio-demographic factors that influence anticipatory self-efficacy in coping with labour pain; determine the relationship between

obstetric factors such as parity and previous labour experience and anticipatory self-efficacy; and ascertain the level of anticipatory self-efficacy among pregnant women in managing labour pain during the first stage of labour.

Two hypotheses were raised for the study

H_1:   There is no significant difference in the parity and anticipatory self-efficacy of coping with labour pain in the in first stage of labour among pregnant women.

H_3:   There is no significant difference between the previous labour experience and anticipatory self-efficacy of coping with labour pain in the first stage of labour among pregnant women.

METHODS

This study employed a non-experimental descriptive research design, which allowed for an accurate and valid representation of factors influencing anticipatory self-efficacy among pregnant women in coping with labour pain during the first stage of labour. The target population comprised pregnant women attending antenatal clinics at State Hospital, Ijaiye, Abeokuta, Ogun State. Based on hospital records, the average monthly attendance of pregnant women totalled 180, distributed across four weeks: 35 in week one, 44 in week two, 52 in week three, and 49 in week four. Inclusion criteria for participants included being multigravida with previous labour experience, vaginal delivery, no psychological complications during pregnancy, no history of precipitate or prolonged labour, and delivery of a live, healthy infant. Exclusion criteria ruled out pregnant women with existing medical issues or psychiatric conditions requiring caesarean section or special medical intervention.

To determine the appropriate sample size, the researcher applied the formula by Scheaffer, Mendenhall, and Ott (2012), using parameters such as the population size (N = 180), a desired margin of error of 0.05, and a proportion estimate (P = 0.5). After computation, a sample size of 124 was determined and adjusted to 136 to account for a 10% attrition rate. A convenient probability sampling technique was employed to select participants. Data was gathered using a structured and self-developed questionnaire adapted from a previously validated instrument used in studies from Northern Ireland and Australia. The questionnaire consisted of three sections: socio-demographic information (Section A), obstetric characteristics (Section B), and an adapted version of the Childbirth Self-Efficacy Inventory (CBSEI) (Section C). This instrument was translated into Yoruba to ensure comprehension among non-English speaking respondents and maintained the original meaning. Only two parts of the original four-subscale, 62-item CBSEI were utilised for this study.

To ensure the reliability and validity of the instrument, the researcher referred to existing literature confirming the CBSEI's strong psychometric properties. Previous research has shown high internal consistency of over 0.90 in Australian and Northern Irish samples (Drummond et

al., 2014; Sinclair & O'Boyle, 2011). Further validation was carried out through a test-retest method using a small group of pregnant women at State Hospital, Ijebu-Ode. The internal consistency of the instrument for this study yielded a Cronbach's alpha coefficient of 0.75, indicating acceptable reliability. Pre-testing confirmed that the questionnaire was understandable, precise, and culturally appropriate for the population under study.

For data collection, a letter of introduction was obtained from the School of Nursing Science, Babcock University, and ethical approvals were secured from Babcock University Health Research Ethical Committee (BUHREC), as well as the ethics committees of State Hospital Ijaiye and Federal Medical Centre, Idi-Aba. The study's purpose was explained to eligible participants, and informed consent was obtained. Confidentiality and anonymity were ensured. Five trained research assistants assisted in questionnaire distribution, and of the 136 questionnaires administered, 125 were valid and analysed. Data analysis involved the use of SPSS version 20. Descriptive statistics (frequency, percentage, mean, and standard deviation), t-tests, and one-way ANOVA were used to interpret the findings, which were presented in frequency tables and percentages

RESULTS

Preliminary analyses were conducted on data using descriptive statistics. It should be noted, however, that one hundred and twenty-five (125) respondents were recruited and participated in this study. All questionnaires were distributed, all questionnaire were adequately filled, returned and used in the analysis. Thus, 100% questionnaire retrieval success was ensured.

Table 1:Respondents Demographic Characteristics (N = 125)

N	Variable		Frequency	Percent (%)
1	Age	18-25yrs	26	20.8
		26-33yrs	46	36.8
		34-41yrs	38	30.4
		42yrs above	15	12.0
		Total	125	100.0
		Mean age = 33.128; Std. Dev. = 11.001		
2	Educational level	No formal educ.	11	8.8
		Primary educ.	43	34.4
		Secondary educ.	54	43.2
		Tertiary educ.	17	13.6
		Total	125	100.0
3	Religion	Christianity	76	60.8
		Islam	36	28.8
		Others	13	10.4
		Total	125	100.0

4	Monthly Income	No income	-	-
		10,000 or less	22	17.6
		10000-30000	54	43.2
		31,000 above	49	39.2
		Total	125	100.0
5	Parity	1	28	22.4
		2	55	44.0
		3	27	21.6
		4 and above	15	12.0
		Total	125	100.0

In Table 1, the age range reveals that 26 (20.8%) of the respondents were within the ages 18-25 years, 46 (36.8%) were 26-33 years of age, 38 (30.4%) were 34-41 years of age, and 15 (12%) were 42years above. About 43.2% of the respondents had secondary education and 76 (60.8%) reported to be Christians. In relation to income 54 (43.2%) earned a monthly income of #10,000 to #30,000. The participants' obstetric history revealed that 55 (44%) have earlier had 2 kids, 28 (22.4%) had a child, 27 (21.6%) had 3 kids, and 15 (12%) had 4 and above kids.

Table 2: Socio-demographic relationship of anticipatory self-efficacy of pregnant women in coping with labour pain in first stage of labour

N	Variable		Frequency	%	X^2	Sig
1	Age	18-25yrs	26	20.8		
		26-33yrs	46	36.8		
		34-41yrs	38	30.4		
		42yrs above	15	12.0		
2	Educational level	No formal educ.	11	8.8	16.909	0.007
		Primary educ.	43	34.4		
		Secondary educ.	54	43.2		
		Tertiary educ.	17	13.6		
		10,000 or less	22	17.6		
		10000-30000	54	43.2		
		31,000 above	49	39.2		

Table 2 shows that the chi-square value obtained for socio-demographic factors is ($x^2 = 16.909$, p = .007) at the significant levels of less than 0.05. Since this p-value was less than 0.05 values, it could be said that socio-demographic factors have a relationship with anticipatory self-efficacy of pregnant women in coping with labour pain in first stage of labour.

Table 3: Analysis output for significant relationship between the obstetric factors and anticipatory self-efficacy of pregnant women in coping with labour pain in first stage of labour

Variable	Category	N	Mean	X^2	p-value
Obstetric factors and coping with labour pain in first stage of labour	1	28	38.111		
	2	55	40.505	28.899	.012
	3	27	45.765		
		15	45.879		
	4 and above				
	Positive	79			
Previous labour experience	Negative	46			

Table 3 shows a statistical significant relationship between the obstetric factors and anticipatory self-efficacy of pregnant women in coping with labour pain in first stage of labour. This is so because the calculated chi-square value of 28.899 is significant at the p-value of less than .012. Going through the mean scores of self-efficacy of pregnant women in coping with labour pain in first stage of labour, it could be seen that those that had more than a child and had positive labour experience have higher anticipatory self-efficacy in coping with labour pain in first stage of labour

Table 4: Information on the anticipatory self-efficacy of coping with labour pain among pregnant women in first stage of labour

Self-efficacy level	Category of scores	First stage of labour	
		Freq	%
Low	1-25	48	38.4
Average	26-50	66	52.8
High	51-75	11	8.8
Total		125	100
Mean		42.565	
Standard dev.		13.488	

Table 4 presents the level of anticipatory self-efficacy of coping with labour pain among pregnant women in first stage of labour. The respondents' level of anticipatory self-efficacy of coping with labour pain in first stage of labour was on the average. The mean score was 42.567 which is equivalent to 56.8%. Thus, it could be said that the level of self-efficacy in coping with labour among the participants in the first stage of labour was moderate. This is because their mean score is higher than 50%.

Hypotheses Testing

Ho1. There is no significant difference in the parity and anticipatory self-efficacy of coping with labour pain in the in first stage of labour among pregnant women.

Table 5: One Way Analysis of Variance (ANOVA) analysis on the difference in the parity and anticipatory self-efficacy of coping with labour pain in the in first stage of labour among pregnant women

Sources of Variance	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	62.188	1	62.188	2.787	.001
Within Groups	2745.114	123	22.318		
Total	2807.302	124			

In order to assess the significant difference in the parity and anticipatory self-efficacy of coping with labour pain in the in first stage of labour among pregnant women, one way Analysis of Variance (ANOVA) was the main statistical method used. The calculated value of f = 2.786 was significant at 0.01 alpha level indicated that there is a significant difference in the parity and anticipatory self-efficacy of coping with labour pain in the in first stage of labour among pregnant women. Therefore, the earlier set null hypothesis was rejected while the alternative one is accepted.

Ho2: There is no significant difference between the previous labour experience and anticipatory self-efficacy of coping with labour pain in the first stage of labour among pregnant women

Table 6: Independent t-test to shows the difference between previous labour experience and anticipatory self-efficacy of coping with labour pain in the first stage of labour among pregnant women

	N	Mean	Std. Deviation	Std. Error Mean	df	T	Mean diff	Sig
Positive	79	47.586	8.543	.901				
Negative	46	41.448	10.001	.818	123	5.303	6.138	.000

Results in Table 6 indicate a significant difference between previous labour experience and anticipatory self-efficacy of coping with labour pain in the first stage of labour among pregnant women (t = 5.303, df = 123, mean diff. = 6.138, p = 0.00). Hence the earlier set null hypothesis that stated that "There is no significant difference between the previous labour experience and anticipatory self-efficacy of coping with labour pain in the first stage of labour among pregnant women" was rejected while the alternate one is sustained.

DISCUSSION OF FINDINGS

The findings of this study revealed a significant relationship between age and anticipatory self-

efficacy in coping with labour pain during the first stage of labour. While previous studies have yielded inconclusive evidence on the influence of socio-demographic factors on childbirth self-efficacy, this study offers clarity on the role of age in shaping women's confidence in managing labour pain. Said., et al. (2022) noted a lack of consistent evidence linking self-efficacy with age, cohabitation, or occupational status (Korn et al., 2021; Kjeldsen et al., 2022). However, the current study aligns with , Pietrzak (2014), as well Mędrzycka-Dąbrowska, Ferber et al. (2016), who reported that women with formal education were significantly more prepared for childbirth. This finding reinforces the importance of educational attainment in equipping women with the knowledge and psychological readiness necessary to cope with the demands of labour (Isgut et al., 2017). Similarly, (Kuo et al. 2022) found that educated women were 2.5 times more likely to prepare for childbirth than their less-educated counterparts, highlighting the critical role of education in enhancing childbirth readiness and self-efficacy.

Additionally, the study demonstrated a statistically significant relationship between obstetric factors particularly parity and anticipatory self-efficacy in coping with first-stage labour pain. Women with more than one child exhibited higher levels of self-efficacy, suggesting that prior childbirth experience plays a pivotal role in building confidence and preparedness for subsequent labour experiences (Kulak-Bejda et al., 2024). Pain is a central concern for many pregnant women, and their ability to anticipate and manage it effectively can be shaped by previous obstetric outcomes. These findings corroborate those of Navarro-Prado et al. (2023), who found that obstetric characteristics significantly influenced childbirth self-efficacy. Multiparous women tend to have higher self-efficacy, likely due to previous positive labour experiences, as supported by Rúger-Navarrete et al. (2023) and Lee et al. (2015). Conversely, women with a history of negative birth events, such as caesarean sections, have been reported to exhibit lower self-efficacy (Mroz et al., 2023; Moran et al., 2014). These insights suggest that obstetric history is a powerful determinant of how well a woman anticipates her ability to manage labour pain, emphasising the need for tailored interventions based on individual reproductive histories (Avery et al., 2018).

Furthermore, the general level of anticipatory self-efficacy among respondents for coping with first-stage labour pain was found to be average. This outcome echoes previous research that positions self-efficacy as a crucial psychological resource influencing individuals' responses to adversity and stress. Studies by Baker et al. (2015) and Conqueiro et al. (2017) have identified self-efficacy as a key determinant of psychological resilience, with implications for both physical and mental health. Likewise, Bialas et al. (2024) and Schwartz et al. (2015) linked higher self-efficacy to improved subjective well-being and adaptive coping strategies. The average self-efficacy levels observed in this study suggest that while many women may feel moderately confident about managing labour pain, there remains a critical need for interventions aimed at boosting self-efficacy through antenatal education, support groups, and prior labour debriefings. The literature affirms that targeted psychosocial support can significantly enhance a woman's belief in her ability to cope with labour, ultimately leading to

better childbirth outcomes and maternal satisfaction.

CONCLUSION

Based on the findings of this study, it is concluded that nursing interventions are essential to help pregnant women improve their self-efficacy in coping with labour pains, particularly during the first stage of labour. Although the level of anticipatory self-efficacy for coping with first-stage labour pain was found to be average, there is a critical need to promote and enhance positive coping strategies. Encouraging pregnant women to adopt effective coping measures can significantly improve their ability to manage labour pain during the first stage, ultimately leading to better delivery outcomes and protection for the mother, unborn child, and their families. Furthermore, the study highlights that increased anticipatory self-efficacy during the first stage of labour is influenced by factors such as age, educational status, parity, and previous labour experience. Therefore, midwives should prioritise training and psychosocial support during antenatal care to build women's confidence and preparedness for labour, fostering a more positive childbirth experience and improved maternal well-being.

Recommendations

1. Midwives and other maternity healthcare providers should incorporate structured self-efficacy and coping strategy training into routine antenatal classes. This training should include practical techniques such as breathing exercises, visualisation, and pain management education to enhance pregnant women's confidence and preparedness for labour.
2. Healthcare professionals should provide personalised antenatal support based on women's age, parity, educational level, and previous labour experience. Special attention should be given to primigravida women and those with negative prior experiences to boost their anticipatory coping skills.
3. Midwives should receive ongoing training on the psychological aspects of childbirth, particularly in enhancing maternal self-efficacy. This will enable them to better support and empower women throughout pregnancy and especially during the first stage of labour.

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